ATTENDING PHYSICIAN'S STATEMENT

Section A **Employee Information:** ***(to be completed by employee)***

Name: ______________________ Primary Phone #: ______________________

Address: ______________________ City: ______________________

Email Address: ______________________ Postal Code: ______________________

______________________ Job Title: ______________________

LAST DAY WORKED: __________________ **FIRST MISSED SHIFT:** __________________

Section B **Consent:** (to ***be completed by employee)***

I authorize the physician/practitioner to disclose information to Occupational Health & Wellness, St. Joseph's Care Group regarding my medical condition as it relates to my current absence from work by completing Sections C and D (below) for the purposes of validating and managing my claim for a medical leave of absence, as it relates to my fitness for work.

I understand that Occupational Health & Wellness, St. Joseph's Care Group will keep my medical information confidential but for the purpose of facilitating my return to work. I consent to allow Occupational Health & Wellness, St. Joseph's Care Group to relate my claim status, my absence duration and my ability to return to work with or without restrictions to my employer. I also consent to allow Occupational Health & Wellness, St. Joseph's Care Group to share nonmedical information with my employer as it relates to my current absence for the purpose of facilitating my return to work (if applicable).

A photocopy of this authorization is as valid as the original.

______________________________ ______________________________

Signature Date

Section C ***(to be completed by qualified medical doctor or qualified mental health professional)***

Date first assessed to be totally disabled from all duties: ______________________________

Expected period of absence (total disability): ______________________________

General nature of illness or injury
(without disclosure of diagnosis): ______________________________

Is this absence work related: ☐ Yes ☐ No

Employee is under active treatment: ☐ Yes ☐ No

Please describe treatment provided and plan: ______________________________

Anticipated return to work date: ______________________________

Complete recovery expected: ☐ Yes ☐ No

PLEASE TURN OVER >

Section D

Employee name:____

We support early safe and timely return to work. We are committed to providing modified duties to support the recovery process. Please fully complete the appropriate box below.

☐ **Fit to return to full duties**:

Date:

☐ **Employee unfit to work:** Please describe the functional impairment that is preventing this employee from performing **any and all work**:

Duration: Reassessment Date:

☐ **Employee fit for Modified Work:** Please indicate specific functional limitations:

Duration: Reassessment Date:

By affixing my signature below, I certify that I am a qualified medical doctor or a qualified mental health professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

PHYSICIAN'S NAME: (Please Print)____

ADDRESS: ____

TELEPHONE: ______________________ FAX: ______________________

SIGNATURE: ______________________ **DATE:** ______________________

Return form by confidential fax, email or mail to Occupational Health & Wellness.

Confidential Fax #: 807-346-2353 Email : OccHealth@tbh.net

Address: St. Joseph's Hospital, 35 Algoma Street North , P.O. Box 3251, Thunder Bay, Ontario P7B 5G7

Questions about this collection should be directed to the Freedom of Information Coordinator,
580 Algoma St. N., Thunder Bay, Ontario, P7B 5G4, Phone: (807) 346-5238, E-mail: foi-sjcg@tbh.net